City of Fond du Lac
2022 OPEN ENROLLMENT

ELECTIONS DUE BY 11/26/21

The 2022 Open Enrollment period will extend October 28 – November 26, 2021. Please complete the elections below for health insurance, the flexible benefit cafeteria plan, dental insurance and vision insurance. Find supporting documentation in the Open Enrollment e-Binder or online at: www.fdl.wi.gov/hr/employee-resources/benefits/. Reach out to Human Resources with any questions.

EMPLOYEE INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____
Address: _____ City, State, Zip: _____
Phone Number: _____ Dept./Division: _____
Email Address: _____

A. HEALTH INSURANCE

a. Select only one of the following options:

- ☐ I choose to enroll in the **Employee Only** coverage. *(Continue to section b)*
- ☐ I choose to enroll in the **Family** coverage. *(Continue to section b)*
- ☐ I choose to **waive** City of Fond du Lac health insurance coverage. *(Continue to section c)*

b. Do you or any family member currently have other health coverage? *(If yes, provide information below)*

☐ Yes, Single ☐ Yes, Family ☐ No *(Continue to section c)*

Name of Policy Holder: _____ Employer: _____
Insurance Name: _____ Plan Number: _____

c. Enrollment signature:

ENROLLING IN HEALTH INSURANCE COVERAGE

I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover all contributions for coverage.

Signature: _____ Date: _____

OR

WAIVING HEALTH INSURANCE COVERAGE

I attest that I am declining group health coverage because I am currently enrolled in other group health or insurance coverage. I freely and voluntarily waive all health insurance coverage noted above.

Signature: _____ Date: _____

B. FLEXIBLE BENEFIT CAFETERIA PLAN (SECTION 125)

a. Select only one of the following options:

- ☐ I choose to **elect**. *(Continue to section b)*
- ☐ I choose to **waive**. *(Continue to section d)*

b. Annual Election Amounts:

Unreimbursed Medical/Dental/Vision: _____ (Annual Max $2,750)
Dependent Care: _____ (Annual Max $5,000)

***For direct deposit, you must complete the form found in the e-Binder or visit the HPS portal.**

c. Automatic Rollover Election – only allowed if you elect health insurance through the City of Fond du Lac AND nobody in your family has additional insurance. Note: claims for dependents over 18 years of age will not automatically rollover and will need to be manually submitted.

If you elect automatic rollover, the claims that go to HPS can automatically be "rolled over" into your flex plan as an automatic claim under Flex for out-of-pocket amounts: deductibles, copays, coinsurance, etc.

☐ Yes, elect automatic rollover ☐ No, I will submit my claims

d. Enrollment signature:

ENROLLING IN THE FLEXIBLE BENEFIT CAFETERIA PLAN

I hereby authorize the City of Fond du Lac to reduce my gross monthly wages on a pre-tax basis by the amounts stated for the expense period (Jan 1, 2022 – March 15, 2023). Each of the amounts indicated are reimbursable and satisfy the requirements of the Section125 Flexible Benefit Plan.

Signature: Date:

OR

WAIVING THE FLEXIBLE BENEFIT CAFETERIA PLAN

I acknowledge that I have been informed of the above reference plan. I hereby elect not to participate.

Signature: Date:

C. DENTAL INSURANCE

a. Select only one of the following options:

- ☐ I choose to enroll in the **Employee Only** coverage. *(Continue to section b)*
- ☐ I choose to enroll in the **Employee & Spouse** coverage. *(Continue to section b)*
- ☐ I choose to enroll in the **Employee & Child(ren)** coverage. *(Continue to section b)*
- ☐ I choose to enroll in the **Family** coverage. *(Continue to section b)*
- ☐ I choose to **waive** dental insurance coverage. *(Continue to section c)*

b. I want to elect coverage with:

- ☐ Care Plus
- ☐ Delta Dental

c. Enrollment signature:

ENROLLING IN DENTAL INSURANCE COVERAGE

I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance.

Signature: Date:

OR

WAIVING DENTAL INSURANCE COVERAGE

I freely and voluntarily waive all dental insurance coverage noted above.

Signature: Date:

D. VISION INSURANCE

a. Select only one of the following options:

- ☐ I choose to enroll in the **Employee Only** coverage.
- ☐ I choose to enroll in the **Employee & Spouse** coverage.
- ☐ I choose to enroll in the **Employee & Child(ren)** coverage.
- ☐ I choose to enroll in the **Family** coverage.
- ☐ I choose to **waive** vision insurance coverage.

b. Enrollment signature:

ENROLLING IN VISION INSURANCE COVERAGE

I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance.

Signature: Date:

OR

WAIVING VISION INSURANCE COVERAGE

I freely and voluntarily waive all vision insurance coverage noted above.

Signature: Date:

DEPENDENT INFORMATION – REQUIRED

Legal Marital Status: ☐ Married ☐ Not Married

Name (First & Last)		Social Security Number	M / F	Birth Date (MM/DD/YY)	ENROLL IN: Health (Y/N)	Dental (Y/N)	Vision (Y/N)
Employee:							
Spouse:							
Child:							
Child:							
Child:							
Child:							
Child:							
Child:							
Child:							
Child:							

CERTIFICATION INFORMATION

A. I certify that all of the above information is true and correct. I understand that elected coverages will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I understand that I may not change the coverage elections that I make until the plan's next open enrollment period or I meet the exceptions allowed under law. *(i.e. qualifying life event)*

B. I authorize deductions from my earnings for the amounts required, if any, to cover any/all contributions for coverage.

C. Specific to the Flexible Benefit Cafeteria Plan (Section 125). I understand that:

   a. If at the end of the expense period, the total declared reduction in compensation exceeds the substantiated expenses, the IRS requires that any unused amount become the property of the employer and may not be paid to me in cash or used to provide benefits in a later plan year.

   b. I can no longer deduct these expenses from my individual State and Federal income tax returns since they will be paid with non-taxed income.

   c. I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have changes in family status or the City of Fond du Lac determines I meet the exceptions allowed under law to permit a change or revocation of an election.

   d. The City of Fond du Lac will deduct any additional premiums during the plan year if my fixed premium amounts increase.

   e. The City of Fond du Lac may reduce or cancel my compensation redirection or otherwise modify this agreement in the event it is believed advisable in order to satisfy certain provisions of the IRS Code.

   f. This reduction in my taxable wage base will reduce my wages for Social Security purposes and may reduce Social Security benefits to be paid at death, retirement, or disability. I agree to hold harmless the Administrator and its representatives for any loss of Social Security Benefits, which is a result of participation in the Section 125 Plan.

Signature: _____ **Date:** _____

City of Fond du Lac

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FLEXIBLE BENEFIT CAFETERIA PLAN (SECTION 125)
Enrollment Agreement/Affidavit

ENROLLMENT INFORMATION: Expense Period – January 1, 2022 through December 31, 2022

Name_____SSN_____Date of Birth_____

Address_____City_____State_____Zip_____

Date of Hire_____ Date of Eligibility _____Pay Cycle: **B**
Bi-weekly

By enrolling, I understand that:

1. If at the end of the expense period, the total declared reduction in compensation exceeds the substantiated expenses, the IRS requires that any unused amount become the property of the employer and may not be paid to me in cash or used to provide benefits in a later plan year.
2. I can no longer deduct these expenses from my individual State and Federal income tax returns since they will be paid with non-taxed income.
3. I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse or such other events as the Plan Administrator determines will permit a change or revocation of an election).
4. The Plan Administrator will deduct any additional premium during the plan year if my fixed premium amounts increase.
5. The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event it is believed advisable in order to satisfy certain provisions of the Internal Revenue Service Code.
6. This reduction in my taxable wage base will reduce my wages for Social Security purposes and may reduce Social Security benefits to be paid at death, retirement, or disability. I agree to hold harmless the Administrator and its representatives for any loss of Social Security Benefits, which is a result of participation in the Section 125 Plan.
7. ***Total Annual Maximum Election amount allowed for Unreimbursed Medical Expenses Plan is $2,750.00***

Yes, I want to enroll. This agreement is subject to the terms of the Plan Document for the above-named Flexible Benefit Cafeteria Plan, in effect and as amended from time to time, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation redirection agreement relating to such plan(s). Under penalties or perjury, I certify that I have examined this affidavit and to the best of my knowledge and belief, it is true, correct and complete.

Employee's Signature: _____Date: _____

PARTICIPATION/REDUCTION AMOUNTS: I hereby authorize **City of Fond du Lac**, hereinafter referred to as the Plan Administrator, to reduce my gross monthly wages on a pre-tax basis by the amounts stated below for the above expense period. Each of the amounts indicated are reimbursable and satisfy the requirements of the Section 125 Flexible Benefit Plan.

Annual Election Amounts

A. Unreimbursed Medical $_____ (Annual Max $2750)

B. Dependent Care $_____ (Annual Max $5000)

Annual amounts will be broken down by pay period and may be rounded, if necessary.

Automatic Rollover Election

This option may be elected if City of Fond du Lac is also providing administration for your medical plan. If you elect Automatic Rollover, eligible out of pocket amounts from claims processed under the medical plan will be "rolled over" as an automatic claim under your flex plan. ***If anyone in your family has ADDITIONAL insurance, (City of Fond du Lac coverage plus other insurance coverage) automatic rollover cannot be elected. Please note: Claims for dependents over 18 years of age will not automatically rollover and will need to be manually submitted.***

If no one has other insurance, and you have City of Fond du Lac as a Medical Administrator, you have the option to mark "Yes" to Automatic Rollover.

Do I want Automatic Rollover (circle one, left blank it is an automatic "No"): Yes No

No, I don't want to enroll in Flex. I acknowledge that I have been informed of the above referenced plan. I hereby elect not to participate. I understand that this waiver will remain in effect for the remainder of this plan year, but that I may decide to participate in later plan years by making an election to participate during the election period prior to each plan year.

Employee's Signature: _____ Date: _____

FLEXIBLE SPENDING ADMINISTRATION

Direct Deposit Form:

Employer: _____

Employee: _____

Social Security#: _____

Address: _____

City: _____

State: _____ Zip: _____

I wish to receive my flexible spending reimbursements by Direct Deposit. I hereby authorize Auxiant to originate electronic credit transactions to my bank, credit union, or savings and loan account indicated below and to credit the same to such account. If necessary, Auxiant may make deductions from my account for any payments credited to my account in error. This authority is to remain in full force and effect until Auxiant has received written notification from me of its termination in such time as to afford Auxiant and my bank a reasonable opportunity to act on it.

Bank: _____

Routing #: _____

Account #: _____

Type: ☐ Checking ☐ Savings

Signature: _____ Date: _____

Is this a change to a current authorization? ☐ Yes ☐ No

Please attach a voided check to this form for verification of routing and account numbers.

Send completed forms to:
Auxiant
Attn: Flexible Spending Department
P.O. Box 75008
Cedar Rapids, IA 52407-5008

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Dependent Childcare Annual Request Form 2022
For "Standing Request Reimbursement"

Employee Information:

Employer _____

Employee _____ SSN _____
Last First Middle

Address: _____
Street City State Zip Code

Phone Number (____) _____

Eligible Dependents: _____

_____

Daycare Provider Information:

Name _____ Tax ID _____

Address _____
Street City State Zip Code

Phone Number (___) _____

Standard Fee $_____ per [] Week [] Month
[] Other* _____
*(may require additional information)

Service Effective Date: _____ thru _____

(Only service dates between **01/01/2022 and 03/15/2023** are eligible for reimbursement during the **2022** plan year. This form must be filled out every year in order to receive standing reimbursement.)

Daycare Provider's Signature _____ Date _____

I certify that the above information is correct. In the event that there are any changes and/or reductions in the above fees, I will notifyAuxiant immediately to discontinue automatic reimbursement until such time that I deliver new documentation for my amended Annual Request.

Employee's Signature _____ Date _____

Note: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the plan year or the earned income of your spouse. If your spouse is either a full-time student or is incapable of taking care of themselves, then they are deemed to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes or is your child or stepchild and is under age 19.

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